

## Viewpoints

### Ten years on: time for a public health celebration or sober reflection?

Ten years ago Malta was deeply divided into two camps: those in favour and those against membership of the European Union (EU). The referendum was a narrow victory for supporters of membership, and the rest is history.

At the time of accession, the health sector was not one of the key areas targeted for debate or scrutiny.<sup>1</sup> This may have been due to the fact that European competence in health was limited and Member State competence in matters of health policy was held to be supreme.

The potential 'brain drain' resulting from the free movement of health-care professionals was highlighted at the time of enlargement.<sup>2</sup> While professional mobility is a complex phenomenon, recent analysis of data indicates that although the numbers of doctors from the new EU 12 present in the old EU 15 more than doubled between 2003 and 2007, estimated outflows have rarely exceeded 3% of the domestic workforce.<sup>3</sup>

Malta was particularly concerned about the potential loss of health-care professionals to other countries.<sup>4</sup> Shortly after accession, ~80% of newly graduated doctors started to migrate annually. This situation called for immediate action and the government set up a Foundation School under the auspices of the UK Foundation Programme. This initiative taken at national level was effective in halting this mass migration.

Over the years a strong postgraduate training programme has developed in partnerships with teaching hospitals in other EU countries, and this development was also supported through the European Social Fund.

A second major concern for Malta was related to medicines. Major legislative and administrative reforms were required to adhere to the European legislation.<sup>5</sup> Despite specific provisions, such as the 'Cyprus clause' (Article 126a: registrations are a simplified registration process specifically created to address access in small countries), the number of available medicines in Malta dropped sharply after accession, and market access at affordable prices still remains a significant challenge to contend with to date. The Joint Procurement Initiative being negotiated following the adoption of the Decision on Serious Cross Border Health Threats is a step in the right direction to enhance access and affordability.<sup>6</sup>

Free movement of patients was already prominently on the agenda in 2004. Malta was concerned that patients would seek care in other European countries destabilizing the national health system, which is reliant on minimum volumes of interventions to sustain certain services. This concern has not materialized to date primarily because Malta has a long history of bilateral cross-border cooperation with England.<sup>7</sup> The utilization of this programme has meant that movement of patients to date has taken place through national instruments rather than through the application of EU rules. The recent implementation of the Patients Rights and Cross-Border Care Directive could hail a change in the trends seen to date. An outflow of patients is most likely to be closely followed by an outflow of expertise, which would mean closure of specialist services and reduced access for persons without means to travel overseas.<sup>8</sup>

On a positive note, the ability to use regional funds for investment in health infrastructure and human resources was an unanticipated benefit. The 2007–2013 Structural and Cohesion Funding Programmes provided Member States with the opportunity to prioritize health investment and ~1.5% of funding went towards health infrastructure. Malta seized this opportunity to develop a specialized cancer facility using European Regional Development Funds (ERDF), and it is estimated that ~5.4% of the European

Regional Development Funds would have been spent on health infrastructure projects by the end of this funding period.

Impetus was also given to the development of national cancer screening programmes for breast cancer and colorectal cancer as a result of the Council Recommendation on Cancer Screening and the subsequent report issued in 2007 highlighting that Malta was one of the only Member States without cancer screening programmes.<sup>9</sup> Although this could be viewed as a gentle, but firm, type of harmonization effort, it must be conceded that often such policy triggers are necessary to overcome non-decision-making often evident in small communities with powerful stakeholder interests.

Public health professionals have benefitted from the networking and training opportunities provided through the Health Programmes, particularly some of the Joint Actions. The role of the European Centre for Disease Control in providing technical guidance and support was particularly important during the H1N1 pandemic.

Malta's health status, which was already more akin to the EU 15 at the time of accession, has continued to improve over the past decade. Over the years, a number of important public health policy strategies have been developed and adopted including the Non-Communicable Disease Strategy, National Cancer Plan 2011–2015, Healthy Weight for Life Strategy and the Sexual Health Strategy. Although it is not possible to associate the adoption of these plans or the improvements in health status with Malta's membership in the EU, the influence of EU public health policies and programmes on health status and health systems is a research topic that merits attention.

To date, from a health perspective, Malta's membership of the EU appears to have a net positive impact. It remains to be seen whether this positive judgement will still hold true if the health system becomes subject to budgetary cuts as a result of the pursuance of economic policy objectives where specific contextual characteristics are not taken into account. The Country-Specific Recommendations derived from the European Semester process aimed quasi-exclusively at addressing sustainability of public finances are worrying examples of European policy, which is threatening to the positive trends in health outcomes seen so far, unless investment in public health and health services is appropriately safeguarded.

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## **Hungarian public health – ups and downs in the last 20 years**

Before 1990 in the era of ‘building socialism’, public health services in Hungary similarly to the other Central Eastern European countries were mostly organized following the Soviet model with a high priority on infectious diseases and carrying out authoritative hygienic and sanitary control measures. The concept of ‘new public health’ as a contemporary application of a broad range of evidence-based scientific, technological and management systems implementing measures to improve the health of individuals and populations became more and more widely accepted only after the regime change in 1989–90. Recognizing that the ‘hygienists’ are not adequately trained to perform high-quality public health services, the Hungarian Government initiated the development of the School of Public Health at the University of Debrecen in the framework of ‘Health Services and Management Program’ (1993–2000). The School served as the basis institute to the establishment of the first Faculty of Public Health in Hungary.<sup>1</sup> At present, the Faculty of Public Health offers a rich variety of learning experience in the field of public health (BSc and MSc courses in public health, MSc in Health Psychology, MSc in Health Policy Planning and MSc in Complex Rehabilitation). Public health training is also delivered in two other universities in the country. In addition, the medical specialization training in Preventive Medicine and Public Health was also developed and launched, and it is running at four training sites. As a result of the educational development efforts, more and more well-trained professionals appeared on the labour market.

The policy framework of public health has shown a remarkable consistency for the past 20 years in Hungary. The first comprehensive programme, which was developed by Prof. Pál Kertai, the first chief medical officer, was launched as a government resolution in 1994. It was followed by renewed public health strategies in 2001 and 2003 as another government and parliament resolutions, which set priorities and defined actions for 10 years. They represented the values and concepts of ‘new public health’. Besides health protection, they emphasized health promotion, prevention of non-communicable diseases and reduction of health inequalities. These public health programmes preserved the leadership of public health in the health sector, but they extended the range of actors to all sectors and advocated partnership between them.

Unfortunately, only a small proportion of the planned actions was implemented because of the lack of long-term political support, inadequate financing, insufficient institutional capacity and the limited intersectoral collaboration. Of the very attractive ‘For a Healthy Nation’ Public Health Program linked to the name of the former Minister of Health, István Mikola, only the breast screening programme was implemented until the governmental change in

2002. In 2003, the Parliament had called on the government to update and expand the public health programme ‘For a Healthy Nation’, and to present the ‘National Programme for the Decade of Health’.<sup>2</sup> In the framework of this programme, actions started basically in all areas of public health under the leadership of State Secretary Zsuzsanna Jakab, the later founding director of European Centre for Disease Prevention and Control and the present Regional Director of the World Health Organization Regional Office for Europe. Soon, it was realized that the available institutional, financial and human resources required focusing the interventions. Intersectoral Public Health Committee was established; a population-based cervical screening programme and health promotion programmes for settlements, workplaces and schools were launched. A strategy against AIDS and a National Food Safety Program were developed. In the accession process to the European Union, Hungary has joined the thematic health programmes, like the Health Monitoring Programme.

In 2006–10, public health was not on the health policy agenda. The turbulent political debate on the reform of the health care system detracted almost all attention and resources.

In 2010, the new government defined priorities and short-term actions in its health plan (Simmelweis Plan for the Rescue of Health Care).<sup>3</sup> Public health legislation was effectively used, smoking was banned totally from public and work places and point of sales of tobacco was reduced to a large extent. Hungary was one of the first countries where companies that place certain pre-packed products on the market must pay public health product tax depending on the sugar, salt, methyl-xanthine and taurine content of the product. Recent surveys have shown that it had an effect on the attitude and consumption of the population. Because of financial austerity, only European Union structural and other external funds are being used for development. The projects include capacity building of institutions that actually provide health promotion and disease prevention services establishment of a National Health Communication Centre within the public health service, health promotion offices in outpatient services, a model project of community-oriented primary care in the framework of the Swiss Contribution Programme,<sup>4</sup> colorectal screening programme and involvement of public health nurses in the cervical screening programme.

Whether these developments are sustainable and whether the modernization of the Hungarian public health system would continue is still a question. The integration of the local branches of the National Public Health Service to the regional and local governmental offices did not increase professional capacities and